Form 316

COWICHAN VALLEY
School District

STUDENT HEALTH QUESTIONNAIRE

Student's Name: _____ Birth Date: _____

Parents/Guardian: _____ Phone: _____

Mother: _____ Home: _____ Work: _____

Father: _____ Home: _____ Work: _____

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1. Does your child have any of the following physician diagnosed conditions?
   a. Diabetes ☐ Yes ☐ No
   b. Epilepsy with a history of seizures in the past 2 years ☐ Yes ☐ No
   c. Severe asthma needing immediate medical treatment or medication to prevent an emergency ☐ Yes ☐ No
   d. Blood clotting disorders, i.e., haemophilia that requires immediate medical care ☐ Yes ☐ No
   e. Severe allergic reactions:
      i) to foods, requiring adrenalin or hospitalization ☐ Yes ☐ No
      ii) to insect stings, requiring adrenalin or hospitalization ☐ Yes ☐ No

      Are any of the allergic reactions life threatening? ☐ Yes ☐ No

      Do any of the allergic reactions require an Epipen? ☐ Yes ☐ No
   f. Any other condition that may require emergency care at school? (if YES, please describe the condition and the care you expect your child to receive at school) ☐ Yes ☐ No

2. Does your child need to take medication on a continuing basis while at school? ☐ Yes ☐ No
3. Does your child need assistance or supervision in taking their medication? ☐ Yes ☐ No
4. Will your child need emergency medication for an allergic reaction or other medical condition? (If YES, please describe) ☐ Yes ☐ No

IF YOU HAVE CHECKED A "YES", PLEASE GET THE APPROPRIATE FOLLOW UP FORM
And schedule a meeting with the principal

_____ _____

Parent/Legal Guardian Signature Date